REFERRAL FORM

NHS
Birmingham Community Healthcare
NHS Foundation Trust

Please complete all sections of the referral form, incomplete referrals will not be accepted.

Child or young person being referred

Surname of Child/Young Person		First Name(s)	
Date of Birth	NHS No.	Male ☐	Female ☐
Address: Postcode:			

Details of Parent/Carer

Parent/Carer's Name (s):		Relationship to child:
Parental Responsibility:	Mother Yes ☐ No ☐	Father Yes ☐ No ☐
Address *(if different from above)*:		
Daytime Contact Number/ Mobile *(please ensure this is up to date):*		
Email		
Consent to receipt of SMS Text reminders: Yes ☐ No ☐		

Ethnicity Category

Ethnicity Code *(Please see page 2 for list of codes):*	
Home Language	**Is an Interpreter required?** Yes ☐ No ☐
Will carers have any difficulties reading appointment letters	Yes ☐ No ☐ Don't Know ☐

Details of School/Nursery/Playgroup

Name of School / Nursery / Playgroup / Setting		
a.m.	p.m	all day
Telephone number:		

Details of G.P.

Name and Practice Address:

Child Protection Details (if any)

Child Protection Plan	Yes ☐ No ☐ Unknown ☐
Is the child in the care of the Local Authority:	Yes ☐ No ☐ Type of care order

Early Help Assessment

Early Help Assessment completed	Yes ☐ No ☐ Unknown ☐
Early Help Assessment attached	Yes ☐ No ☐
Integrated Support Plan/ Early Help Plan / Early Support plan	Yes ☐ No ☐ Unknown ☐

Consent/Information Sharing

It is important to ensure that the parent/carer is aware that information detailed in referrals made to Children and Families Division Services may be shared with other health professionals and external agencies such as Education and Social Care.

Has the person with legal responsibility consented to this referral and sharing of information?
Yes **If consent has not been obtained this referral cannot be accepted.**

Referrer Details

Referred by:	Signed:
Designation or Relationship to Child:	
Referrer's full contact address, postcode, telephone:	

REFERRAL FORM

Childs Name:

NHS number:

Date

IMPORTANT:
Please indicate by ticking a box below which service you are referring to. Each referral will require pages 1 and 2 of the referral form and the service specific form. If you are sending a referral to more than one service pages 1 and 2 should be sent with each referral.

NB. A separate form needs to be completed for each service referred to.

- ☐ Community Paediatric Service (Community Paediatricians)

  Note: Referrals to the Child Development Centre should be directed to the Child Health Medical Service.
- ☐ Children's Speech and Language Therapy
  Please indicate: Communication ☐ Eating, Drinking and Swallowing ☐
- ☐ Children's Physiotherapy
- ☐ Children's Occupational Therapy Service
- ☐ Community Children's Nursing & Palliative Care Service
- ☐ ADHD Nursing Service
- ☐ Children's Nutrition and Dietetic Service

IMPORTANT - Is the child currently being seen by or has been referred to:

Professional	Name	Contact Tel No	Base
Health Visitor			
Social Worker			
Medical Consultant			
Other (Health, Education, Social)			

Are there any safety/security issues involved in seeing this client?

No ☐ Yes ☐ If YES, what?

Code	Ethnicity	Code	Ethnicity
A ☐	White British	L ☐	Asian/Asian British Other Background
B ☐	White Irish	M ☐	Black/Black British Caribbean
C ☐	White / Other White Background	N ☐	Black/Black British African
D ☐	Mixed White and Black Caribbean	NKN ☐	Not Known
E ☐	Mixed White and Black African	NS ☐	Not Specified
F ☐	Mixed White and Black Asian	P ☐	Black/Black British Other
G ☐	Mixed Other Background	R ☐	Other Ethnic Groups Chinese
H ☐	Asian/Asian British Indian	S ☐	Any Other Ethnic Group
J ☐	Asian/Asian British Pakistani	T ☐	Eastern European
K ☐	Asian/Asian British Bangladeshi	Z ☐	Not stated

REFERRAL FORM

Childs Name:

NHS number:

Child Health Medical Service / Community Paediatric Service
(Community Paediatric Consultants)

Please enclose with pages 1 to 2 of the referral form
Each area of this form should be completed fully - incomplete forms will be returned.

Diagnosis (if known)

Please tick the developmental areas of concern in the table below

Developmental Areas	No Concerns	Some Concern	Significant Concern
Motor development			
Speech and language			
Social interaction & play (across different situations and settings)			
Self help skills (dressing, use of cutlery, potty training)			
Behaviour and emotional wellbeing			
Attention, concentration & listening		☐	
Learning			

Please elaborate on concerns raised above (if any)

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Childs Name:

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If any behavioural concerns, please elaborate. For Child under 5, Health visitor must have been involved and behaviour intervention initiated.

Medical and relevant birth history

If other professionals involved, please attach relevant information i.e report from CAT (Communication & Autism Team), Pupil support, Educational psychologist, Therapist, Medical etc.

via safe haven fax to:	via email to:
0121 466 3351	BCHNT.commchildref@nhs.net

REFERRAL FORM

Childs Name:

NHS number:

Children's Speech and Language Therapy

PLEASE ENCLOSE WITH PAGES 1 & 2 OF THE REFERRAL FORM

The SLT service works with children 0 - 18 yrs with specific Speech, Language and Communication Needs (SLCN) as well as Eating, Drinking and Swallowing difficulties. Anyone can refer to SLT and the service always works in partnership with parents / carers plus others in nursery / school. The SLT service provides information, advice / strategies and a range of interventions for children who meet the commissioned service thresholds.

Children's needs are profiled in relation to severity of impairment, impact on life, known risks as well as anticipated change in response to therapy and confirmation that others are able to provide the necessary support for the child to progress with the specialist SLT input. These factors are analysed to provide an individual profile and **only the children who meet the commissioned threshold for the service will be seen for intervention.**

It is essential that referrers provide adequate background information about the child's presenting difficulties and about the progress made to date. SLT intervention will only be effective if someone is available to carry out the communication practice in everyday interactions (e.g. family member, carer, member of staff). Incomplete referrals will not be accepted.

The SLT service does not accept referrals for the following: dribbling; written language difficulties (dyslexia); diagnosis of autism spectrum disorder outside of a multi-disciplinary team.

REFERRAL FORM

Childs Name:

NHS number:

Children's Speech and Language Therapy

Each area of this form should be completed fully - incomplete forms will be returned.

Listed below are some of the areas which can be associated with speech, language and communication (SLC) difficulties. Please detail your concerns against the areas below:

	No Concerns	Some Concern	Significant Concern
Eating, drinking and swallowing difficulties	Please detail concerns on table on next page		
Understanding language, words and sentences			
Using words and sentences			
Clarity of speech / pronunciation of words			
Stammering			
Voice			
Social interaction & play (across different situations and settings)			
Attention, concentration & listening			
Learning			
Behaviour and emotional wellbeing			

What additional SLC support (strategies / advice) is already in place? How often? By whom?
(E.g. Local Offer Graduated Response, small group work, visual timetables, signing environment etc.).
What progress has been made? (attach recent targets if appropriate)

REASON FOR REFERRAL

REFERRAL FORM

Childs Name:

NHS number:

Any known medical diagnoses, developmental difficulties or allergies:

Parent / Carer Consent:	
Signature:	Date

Has the child had Speech and Language Therapy previously (NHS or Independent)? Give details below:

Hearing Test?	Not known
Date Carried Out:	Results:
Referral made: Yes ☐ No ☐	Date if recent referral made:
Hearing Aids / Cochlear Implant:	

What National Curriculum / EYFS / alternative levels is the child functioning at?

What training in supporting SLCN have staff in the setting received? (e.g. Early Language Development Programme, Language for Learning, Communication Friendly Schools Birmingham etc.)?

Listed below are some of the features seen which can be associated with Eating, Drinking and Swallowing difficulties. Please detail your concerns against the areas below:

Observed when eating, drinking or swallowing?	Tick below	Comment
Coughing	☐	
Changes in breathing	☐	
Changes in colour	☐	
Eye blinking and/or watering	☐	
Recurrent Chest infections	☐	
Choking	☐	
Gagging	☐	
Vomiting	☐	
Food or fluid refusal	☐	
Distress	☐	

REFERRAL FORM

Childs Name:

NHS number:

Observed when eating, drinking or swallowing?	Tick below			Comment
Lengthy mealtimes				
Weight loss				
Dehydration				
Deterioration of eating, drinking and swallowing skills				
Does the child have any alternative feeding in place e.g. NG tube, gastrostomy?				
Yes ☐ No ☐				
Child ready to progress to new texture or assessment for introduction of tastes				
Yes ☐ No ☐				

If this referral is for a child attending Resource Base where there is an on-site Speech and Language Therapist, please complete and give directly to the Therapist.

All other referrals should be sent:

via post to:
Birmingham NHS Foundation Trust
Children and Families Division
Central Booking Service
Priestley Wharf 2
Holt Street, Aston, Birmingham B7 4BN

via email to: BCHNT.commchildref@nhs.net

via safe haven fax to: 0121 466 3351

REFERRAL FORM

Childs Name:

NHS number:

Paediatric Occupational Therapy Services

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

The Paediatric Occupational Therapy Service is a community based service for children and young people aged 0-18years in the Birmingham area. The service aims to enable children and young people to participate in daily life to improve their health and well-being. Daily life is made up of many activities (or occupations). These may include areas of self-care (getting ready to go out, eating, dressing), nursery/school activities (completing school work, following the school routine) and play/leisure skills (taking part in hobbies, playing sports)

Please note: The Occupational Therapy service accepts referrals from health professionals, Educational Psychology, Social Workers, the Communication and Autism Team and the Physical Disabilities Support Service. The service does not accept referrals from school-based education staff. Schools are requested to discuss their concerns with a health professional and request that they make a referral. This discussion could include the school nurse, therapists, GP or Consultants/Paediatric doctors.

Occupational Therapy intervention will only be effective if someone is able to carry out the recommendations and advice in everyday activities, both at home and in educational settings (e.g. family member, carer, member of staff in setting).

Please note **housing adaptations** and **equipment needs for home** should be referred directly to the Local Authority Occupational Therapy service. Please call (0121) 303 1888 or download a form from www.birmingham.gov.uk : On the home page, type 'children's occupational therapy', in the search box, to access the form.

Requests for **wheelchairs** should be referred directly to BCHC Birmingham Wheelchair Service. The referral form can be downloaded at: http://www.bhamcommunity.nhs.uk/wheelchair

Reason For Referral - please tick the areas that are relevant and provide details of the **main concerns** you have in each of the areas. Describe the impact of these difficulties upon the child's activities of daily living

REFERRAL FORM

Childs Name:

NHS number:

School occupations
Recording of work/handwriting ☐ P.E ☐ Use of scissors ☐
Participation in learning ☐ Following instructions ☐ Attention ☐

Details:

Self-care skills
Participating in mealtimes ☐ Dressing ☐ Toileting ☐
Bathing ☐ Brushing teeth/hair ☐ Eating/drinking ☐

Details:

Play/leisure occupations:
Sports ☐ Riding a bike ☐ Taking part in hobbies ☐ Playing in the playground ☐
Playing ball games ☐ Youth clubs/groups ☐

Details:

Sensory processing:
Please indicate here if you have particular concerns that sensory processing issues may be impacting on the child/young person's performance of everyday activities ☐ e.g. self care, school, play or leisure activities.

Details:

Other ☐

Details:

For Paediatricians only:
If this referral is to contribute towards a potential diagnosis of **Developmental Coordination Disorder/ dyspraxia**, please tick the box. ☐

NB: Please do not refer children who are under 5 years of age for a diagnosis of Developmental Coordination Disorder (DCD). The Royal College of Occupational Therapists: Practice Briefing - November 2013, states that the onset of DCD is apparent in the early years, but the condition would not typically be diagnosed before 5 years of age.

REFERRAL FORM

Childs Name:

NHS number:

What advice has already been given and what strategies are in place? (E.g. fine motor/gross motor groups, previous Occupational Therapy advice sheets etc)

What do you hope the child/young person will gain from this referral?

Additional Information Please include diagnosis and prognosis if known, past medical history (including behavioural or communication issues), medication, referrals made to other agencies and any ongoing medical investigations or issues that may inform our assessment

Initial appointments are held at a clinic. If there is any reason why this might be difficult or if special arrangements are required, please give details below.

via post to:	via safe haven fax to:
Birmingham NHS Foundation Trust Children and Families Division Central Booking Service Priestley Wharf 2 Holt Street, Aston Birmingham B7 4BN	0121 466 3351 via email to: BCHNT.commchildref@nhs.net

REFERRAL FORM

Childs Name:

NHS number:

Paediatric Physiotherapy Service

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

The Paediatric Physiotherapy Service is a community based service for children in the Birmingham area. The service aims are to:

- enable children and young people to reach their full potential;
- maximise function and independence;
- promote normal movement;
- prevent or limit contractures and deformity; and
- improve quality of life

By completing this form you are making a request for a Physiotherapy assessment. A decision to accept this referral will be made according to the nature of the impact on the child in managing activities of daily life.

Referrals will not be accepted for presentations that are normal at certain stages in a child's development e.g. Knock Knees, Bow legs or in-toeing.

NB: Musculo-skeletal referrals for children living in the SOUTH of the city should be sent directly to the Physiotherapy Department at Birmingham Children's Hospital. All other Musculo-skeletal referrals for children aged 14 and over send to MSK Booking Service, Moseley Hall Hospital Fax: 0121 466 6540

Each area of this form should be completed fully - incomplete forms will be returned.

Reason For Referral Please provide details of the difficulties the child is experiencing and where they are not performing at an age appropriate level.

Please give details of how these difficulties impact him/her in the home? (if not already explained above)

Please give details of how these difficulties impact him/her in school/nursery? (if not already explained above)

REFERRAL FORM

Childs Name:

NHS number:

Additional Information Please include diagnosis if known, past medical history (including learning, behavioural or communication issues) and any on-going medical investigations that may inform our assessment.

What specific support would you like from the service? What outcome do you expect for the child?

What strategies/interventions have been tried already ? (E.g. Spoken to Health Visitor /activities/ groups/exercises)

Initial appointments are held in a clinic setting. If there is any reason why this might be difficult please give details below

via post to:	via safe haven fax to:
Birmingham NHS Foundation Trust Children and Families Division Central Booking Service Priestley Wharf 2 Holt Street, Aston Birmingham B7 4BN	0121 466 3351 via email to: BCHNT.commchildref@nhs.net

REFERRAL FORM

Childs Name:

NHS number:

Community Children's Nursing and Palliative Care

Please enclose with pages 1 to 2 of the referral form

Each area of this form should be completed fully - incomplete forms will be returned.

Reason for Referral	Referral to Consultant Yes ☐ No ☐
	(if referral to consultant please state reasons)
Care Required:	
Medical History (e.g. does child have epilepsy):	
Equipment / Dressings Required:	
Any additional information (including expected date of discharge)	

CCN and Palliative Care Team
Lansdowne Health Centre
34 Lansdowne Street
Winson Green
B18 7EE
Tel 0121 245 5775
Fax 0121 245 5781

via secure email to:
ccn.south@nhs.net

REFERRAL FORM

Childs Name:

NHS number:

ADHD Nurse Led Service - (Attention Deficit Hyperactivity Disorder)

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

Each area of this form should be completed fully - incomplete forms will be returned.

Reason For Referral

Current situation, please describe what is happening and when, frequency, duration – giving examples of incidents or events which are having an impact on physical health, education (school), self-esteem, emotional well-being, relationships.

Early developmental history / school

Any concerns at school? Please note we only accept referrals for school aged children.

Yes ☐ No ☐

If yes, please give details

What age were concerns first noted:

Current medication/diagnosis

Please note if aware child has a diagnosis of ADHD we are unable to accept the referral.

Other influences impacting on the current difficulties. Please describe or enclose relevant correspondence

via post to:	via safe haven fax to:
ADHD Service Specialist Nurses Springfield's Centre, Raddlebarn Road Selly Oak, Birmingham B29 6JB Tel: 0121 466 3425	0121 472 7288 via secure email to: adhd.team@nhs.net

REFERRAL FORM

Childs Name:

NHS number:

Nutrition and Dietetic Service Referral Form

Please enclose with pages 1 to 2 of the referral form

Each area of this form should be completed fully - incomplete forms will be returned.

Referral Criteria
Please read our referral criteria on our website: **http://www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/childrens-nutrition-services/** and ensure first line dietary advice has been given where appropriate

Reason for Dietetic input (please tick all that apply)

Selective eating ☐	Allergy / Intolerance ☐	Faltering Growth ☐
Nutritionally Compromised ☐	Enteral Feeding ☐	Modified Texture Diet ☐
Other ☐ Please give details:		

Priority

Urgent ☐ Non-urgent ☐

Expected outcome for Dietetic Input
(e.g. to gain weight, to improve diet, manage food related condition, supplementary feeding etc)

Medical Diagnosis/Condition: Please attach last clinic letter/discharge summary

Relevant recent measurements (e.g. BMI, weight, height)

Comment on history of growth:

Copy of growth chart attached: Yes ☐ No ☐

Relevant Medication

via post to:	via safe haven fax to:
Birmingham Community Nutrition – Paediatric Team 1 Priestley Wharf, Holt Street, Birmingham B7 4BZ Tel: 0121 683 2300	0121 615 2908 via secure email to: referrals.nutrition@nhs.net

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